STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments MEDICARE COMPLAINT SURVEY FOLLOW-UP VISIT The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety complaint follow-up survey. Onsite dates: 06/04/18 to 06/07/18 During the follow-up survey, surveyors also investigated allegations related to complaint intake #80420 and #82072. The survey was conducted by: Surveyor #3 Surveyor #4 Surveyor #5 This follow-up survey resulted from a complaint survey in which the facility was found NOT IN COMPLIANCE with Medicare Conditions for Participation set forth in 42 CFR Part 482. During this on-site follow-up survey, Department of Health staff determined that the facility remained NOT IN COMPLIANCE with the following Medicare Conditions for Participation set forth in 42 CFR Part 482: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient's Rights 42 CFR 482.23 Nursing Services	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 043}	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, document review and interview, the hospital's governing body failed to provide effective oversight of the hospital . Failure to provide effective oversight to prevent substandard practices for patient safety, patient rights, and nursing services resulted in an unsafe environment for patients. Findings included: Observations, interviews, record reviews, and review of hospital policies and procedures, showed the following: 1. The hospital failed to ensure patients received referrals for appropriate medical care during their hospitalization. Cross Reference: A0068 2. The hospital failed to provide for patient safety and protection of patient rights. Cross Reference: A0115 3. The hospital failed to ensure nursing staffwere	{A 043}	**Plan of Correction for Each specific deficiency Cited (A043)** • The Governing Board has taken additional steps to provide effective oversight at hospital to prevent substandard practices for patient safety, patient rights, and nursing services in a safe environment for patients. • The Governing Board has taken additional steps to ensure that patients receive referrals for appropriate medical care during their hospitalization. • The Governing Board has taken additional steps to provide for patient safety and protection of patient rights. • The Governing Board has taken additional steps to ensure that Nursing Staff were trained and available to provide safe and effective care for patient's health care needs. • The Governing Board has taken steps to ensure that the hospital has an effective system to monitor corrective actions for previously identified deficiencies that is robust enough to maintain patient safety. **Procedure/process for implementing the plan of correction:** • The Governing Board approved new/revised policies developed to address these issues on 6/25/2018: • a) Scheduling Services at Another Facility which was revised on obtaining consultations with outside providers. The policy was revised on consultations, obtaining CT scans, and referrals through outside departments. b) Unclothed Body Search/Property Search was revised.	6/25/2018

c)A policy was created for COWs/CIWA on 6/22/2018
d) Patient Identification: The patient identification policy was reviewed with all nurses along with the expectation for its use 6/5/2018 and 6/6/2018.
e) Consultation Services within the facility: Created to steer the in-house referral process.

- The Governing Board approved the action plan to correct CMS cited deficiencies including the provision of education of Nursing Staff and Medical Staff on the new policies and processes, along with Nursing Staff reminder concerning two patient identification process.
- The Governing Board is informed of the monitoring progress of corrective actions in a summary provided by the Director of PI.
- The Governing Board approved bonuses for recruitment of nurses and monitors orientation and training of new staff.
- The Governing Board approved the staffing grid was revised to delineate that the 2nd nurse (if any) may be an RN or an LPN.
- A monthly written report will be circulated to the governing board. A verbal report will be given quarterly if not more frequently as needed.
- The Governing Board will review all reports, comments, and revisions received; and will respond, authorize and/or approve verbally or in writing; thereby ensuring the facility has formal authorization or re-direction. This occurs as frequently as needed, and minimally on a quarterly basis. The documentation will be in the Governing Board minutes.
- The Governing Board will provide supervision related to all aspects to the corrective action plan.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- The Chief Nursing Officer (or

designee) will monitor all consult orders to verify they are obtained in a timely fashion in accordance with the policy on Scheduling Services at Another Facility and will continue this monitoring until 100% of all consults are obtained in a timely fashion for at least 90 consecutive days.

- Nurses who do not properly carry out these protocols will be counseled as appropriate.
- Senior leaders were aware of events per finding 2 cross reference A0115. Corrective actions, re-education, and counseling were provided to staff that did not adhere to SPBH policies to contraband and belongings. Materials from the corrective actions were given to the surveyors while at facility. Nursing re-educated as in-service with nursing staff on proper techniques on using two patient identifiers on 6/5/2018 and 6/6/2018 corrective action and bullet points were provided to surveyors during the survey. Additional retraining commencing 6/26/2018 any nursing staff will not work a shift until re-educated.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice

- The CNO will issue periodic reports to the PI Committee (at least monthly) on the status of obtaining outside consults.
- Corrective actions will be sent to the Governing Board per the report structure. Data will be reported in PI, then to Medical Executive Committee then to the Governing Board.
-

Individual Responsible:

- Chief Executive Officer

Date Completed:

- **6/25/2018**

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{A 043}	Continued From page 2 trained and available to provide safe and effective care for patient's health care needs. Cross Reference: A0385 4. The hospital failed to ensure the system implemented to monitor corrective actions for previously identified deficiencies was robust enough to maintain patient safety. Cross Reference: A0286 Due to the scope and severity of deficiencies detailed under 42 CFR 482.12 Conditions of Participation for Governing Body, 42 CFR 482.13 Condition of Participation for Patient's Rights, and 42 CFR 482.23 Condition of Participation for Nursing Services, the Condition of Participation for Governing Body was NOT MET.	{A 043}		
{A 068}	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and	{A 068}		

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{A 068}	Continued From page 3 (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: Based on interview, document review and medical record review, the hospital failed to ensure patients received referrals for appropriate medical care during their hospitalization. Failure to provide patients with medical services that meet the patient's healthcare needs in a safe environment risks deterioration of the patient's condition and poor healthcare outcomes. Findings included: 1. On 06/05/18 and 06/06/18, Surveyor #5 requested the hospital's referral and consultation policies and procedures. Staff #506 provided Surveyor #5 with a policy and procedure titled, "Scheduling services at another facility," no policy number, effective date 05/17. The policy did not address the hospital's referral or consultation process or procedures. 2. On 06/05/18 at 2:30 PM, Surveyor #5, and Staff #504 and Staff #505 reviewed the medical record of Patient #505 who was admitted on 05/18/18 for the treatment of alcohol addiction, suicidal ideation, and depression. The medical record review showed: a. The initial treatment plan completed on 05/18/18 at 11:45 PM, showed Patient #505 had a dilated right eye. On 05/19/18 at 4:30 PM, the admission medical history, and physical examination showed the patient had a right eye central corneal tear, and the physician completing	{A 068}	**Plan of Correction for Each specific deficiency Cited (A068):** • The hospital failed to ensure that outside consultations and referrals were obtained in a timely fashion. **Procedure/process for implementing the plan of correction:** • A policy was revised (Scheduling Services at Another Facility.) on obtaining CT scans and referrals at outside departments. • Policy was revised on 6/22/2018. • Staff were educated on the new policy and process on 6/26/2018 staff will not work a shift until educated. • A new policy on consultation services within the hospital. Was educated to the staff on 6/26/2018, any staff not trained will not work a shift until educated. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The Chief Nursing Officer (or designee) will monitor and document the review of all ordered consults, referrals, and CT scans to verify completion in a timely manner. This will occur daily, five days per week. 100% of requests and completion of consults, referrals, and CT scans will be monitored until 100% compliance for 90 consecutive days is maintained. • Staff who do not obtain consultations and referrals in a timely fashion will be counseled as appropriately. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions**	6/26/2018

			into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice • The CNO will issue periodic reports to the PI Committee (at least monthly) on the status of obtaining outside CT scans, consultations and referrals **Individual Responsible:** • Chief Nursing Officer **Date Completed:** • **6/26/2018**	

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{A 068}	Continued From page 4	{A 068}		

the form (Staff #507) stated the patient would benefit from seeing an ophthalmologist.

b. On 05/19/18 at 4:40 PM, the medical provider (Staff #507) wrote an order that stated "try to set up an appointment with an ophthalmologist for evaluation of right cornea scarring with central vision axis and try to set up the appointment in a community he plans to live in once discharged."

c. 04/21/18 at 2:14 AM, a dictated history and physical completed by a medical doctor (Staff #507), showed the patient had a central cornea scar causing blurry vision, the patient would benefit from seeing an ophthalmologist in the near future, and the patient should avoid wearing contact lenses. On 05/27/18 at 6:40 PM, the psychiatric nurse practitioner (ARNP) (Staff #508) wrote a provider order for the patient to use daily contact lenses.

d. On 05/30/18 at 12:30 PM, the psychiatric nurse practitioner (ARNP) ordered a medical consult for blurry vision. On 05/30/18 at 8:00 PM, the medical provider's (Staff #507) consultation report showed that the patient had corneal scarring with opacity in the right eye. The provider stated in the report that the patient should not use contact lenses in the right eye, and ordered that the patient receive Tropicamicide (a medication used to dilate the pupil and help with examination of the eye) drops in the right eye twice daily with cool compresses on the right eye as needed for discomfort.

The medical provider wrote and underlined the words, "Pt (patient) needs to see ophthalmologist soon to evaluate right cornea. Note: this was what I recommended at the time of the pt's (patient's)

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{A 068}	Continued From page 5 admission". At the time of the medical record review, Surveyor #5 found no evidence the hospital had scheduled a consultation appointment. 3. At the time of the record review, a registered nurse (Staff #504) stated that the consultation indicated the appointment should occur after the patient was discharged from the hospital. At this same time, a program director (Staff #506) stated that there were difficulties getting an appointment because the patient was a military member and his medical benefits covered care in Texas but not Washington. She stated that the hospital had been in contact with the Veteran's Administration (VA), but they would not cover the cost of the examination. Surveyor #5 found no evidence that the staff had contacted the Veteran's Administration, or that staff had contacted an ophthalmologist or declined a referral. 4. On 06/05/18 at 3:00 PM, during an interview with Surveyor #5, Patient #505 stated that he was still waiting to see an ophthalmologist but he had not received an appointment date or time. He also stated that his glasses were broke in an accident a few weeks prior and he only had contacts available to correct his vision. In compliance with the physician's order, he was not wearing a contact in his right eye. Additionally, he was using drops to dilate his pupils so he could see around the scarring and using compresses for the eye for irritation. 5. On 06/06/18, Surveyor #5 reviewed the discharge medical record for Patient #506, who had been admitted on 04/23/18 for the treatment of alcohol abuse, depression, and anxiety. The medical record review showed:	{A 068}		

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{A 068}	Continued From page 6 a. On 04/24/18 at 7:10 AM, a medical provider completed a consult and wrote an order for a computerized axial tomography (CT) scan for headache, nausea and vomiting, blurry vision and sinus congestion with tenderness. b. On 04/25/18 at 3:30 PM, a provider ordered a medical consult for blurry vision and continued headache. The medical consultation was completed and the CT was reordered. c. An inpatient progress note dated 04/27/18 showed that staff scheduled a CT appointment for 05/04/18. d. On 04/28/18 at 4:40 PM, the patient received another medical consult for continued pain and headache. On 04/29/18 the consultation report stated, "has had three consults for pain andstill no CT of sinus as ordered over one week ago." e. On 04/29/18 at 1:06 PM, a provider order stated, "CT sinuses not done yet, scheduleASAP as has had consult X3 on this condition and CT ordered on 04/24/18. Today or tomorrow schedule CT." 5. On 04/30/18 at 9:00 AM, the Psychiatric ARNP ordered a medical consult to verify if the medical provider wanted the CT completed as a STAT (immediate) order. At 10:30 AM, the medical provider placed an order to send the patient to the emergency room (ER) for a continued intractable headache present since admission and to request that the emergency department complete a CT while the patient was there. On 04/30/18 at 10:30 PM, a consultation report	{A 068}		

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{A 068}	Continued From page 7 stated, "Due to persistent symptoms and delay in approval of CT scan, he (Patient #506) was sent to the ER". THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 3/15/2018	{A 068}	**Plan of Correction for Each specific deficiency Cited (A115)** • The hospital failed to ensure that contraband was not available to patients for self-harm. **Procedure/process for implementing the plan of correction:** • The policy titled "Unclothed Body/Property Search" was revised to no longer allow hoodie type garments on 6/22/2018. • A policy was revised on room searches on 6/22/2018 • Nursing staff were educated on the new policies and process for patient safety. • An investigation was conducted by video review on 6/1/2018 by nursing and the PI director. Nursing was found not to be following policy and a hospital wide re-education was conducted. Nurses involved in incidents were counseled on proper policies and procedures. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The Chief Nursing Officer (or designee) will randomly witness body, belonging and/or a room search for completeness & accuracy (at least five times a week). • The Chief Nursing Officer (or designee) will audit all inspection documents for completeness & accuracy and will continue that auditing until all inspection documents are 100% compliant for at least 90 consecutive days. **Process improvement: Address process**	6/26/2018
{A 115}	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on interview and document review, the hospital failed to provide for patient safety and protection of patient rights. Failure to protect and promote each patient's rights risks patients suffering physiological or psychological harm. Findings included: The hospital failed ensure patients receive care in a safe setting which safeguards vulnerable individuals from self-harm and harm from others. Due to the severity of deficiency under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET. Cross Reference: Tags A0144	{A 115}		

			improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice • The CNO will issue periodic reports to the PI Committee (at least monthly) on the status of skin, belongings and or room checks. **Individual Responsible:** • Chief Nursing Officer **Date Completed:** **6/26/2018**	

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{A 115}	Continued From page 8	{A 115}	**Plan of Correction for Each specific deficiency Cited (A144)** • The hospital failed to ensure that contraband was not available to patients for self-harm. **Procedure/process for implementing the plan of correction:** • The policy titled "Unclothed Body/Property Search" was revised to no longer allow hoodie type garments. • A policy was revised on 6/22/2016 for room searches. • Nursing staff were educated on the new policies and process. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The Chief Nursing Officer (or designee) will randomly witness body, belonging and/or a room search for completeness & accuracy (at least five times a week). • The Chief Nursing Officer (or designee) will audit all inspection documents for completeness & accuracy and will continue that auditing until all inspection documents are 100% compliant for at least 90 consecutive days. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice** • The CNO will issue periodic reports to the PI Committee (at least monthly) on	6/26/2018
{A 144}	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to implement its policies and procedures for patient safety checks to prevent contraband from entering the facility. Failure to detect and prevent contraband and other hazardous items from entering or being available in the hospital risks patient, visitor, and staff safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Unclothed Body Search/Property Search," no policy number - effective 05/17, showed that personal possessions are searched on admission and as clinically indicated to ensure a safe environment for all patients. Restricted items are sent home or secured in the patient's cubicle. Hospital staff can execute a room search for contraband consistent with unit guidelines and for cause, if directed by the patient's physician. Document review of the hospital's policy and procedure titled, "Drug Free Facility," no policy number - effective 05/17, showed that the hospital does not permit illegal drugs on the premises of Smokey Point Behavioral Hospital	{A 144}		

			the status of skin, belongings & room checks. **Individual Responsible:** • Chief Nursing Officer **Date Completed:** • **6/26/2018**	

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{A 144}	Continued From page 9 (SPBH). The hospital does not permit abuse of prescription medications at SPBH. The hospital strictly prohibits use, possession, sale or transfer of illegal drugs or prescription medications on and off hospital property. Client use, possession, sale or transfer of illegal drugs or prescription medications may result in termination of client attendance at the program. Document review of the hospital's contraband list form titled, "Smokey Point Behavioral Hospital Visitation and Items NOT permitted in the Hospital," policy number 050 - updated 03/16/17, included any illicit substances (suspicious items that could be alcohol, drugs, marijuana, etc.). The contraband list showed that "all medications must be administered by the doctor and, checked in with patient upon admission." 2. On 06/04/18 at 1:45 PM, Surveyor #3 interviewed the hospital educator/nursing supervisor (Staff #302) and a registered nurse (Staff #303) about Patient #304 who was on suicide and self-harm precautions at the time of the interview. Surveyor #3 asked Staff #302 why the patient was on suicide and self-harm precautions. Staff #302 stated that Patient #304 would frequently cut himself and the hospital had recently sent the patient to a local hospital emergency room after taking some medications given to him by another patient . Staff #302 also stated that Patient #303 had smuggled in some drugs and shared them with other patients. The staff member stated that she believed the patient brought the medication "Xanax" (an antianxiety medication). Surveyor #3 asked how Patient #303 was able to bring in drugs into the hospital. Staff #302 stated	{A 144}		

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{A 144}	Continued From page 10 that it appeared to be a failure in the admission process. During the admission process, admitting staff perform a safety check, which includes a contraband search of the patient's belongings and clothing. Staff removed from the patient's possession, all items that may be harmful to other patients, visitors, or staff. Surveyor #3 asked Staff #302 and #303 what steps the hospital staff took after they sent Patient #304 to the emergency room. Staff #302 stated that staff performed a contraband search on all the patient rooms. Staff found additional pills in Patient #303 and #304's rooms. The hospital ordered a drug screen for all patients on the nursing unit. The hospital also changed the procedure for patients requesting their personal items from storage. Hospital staff thought Patient #303 accessed her personal belongings in order to retrieve the drugs stored in her belongings. The current process requires that staff retrieve patient items and check them for illicit/hazardous items prior to handing them to the patient. Surveyor #3 asked Staff #302 and #303 if there were any more incidents surrounding Patient #304. Staff #302 stated that Patient #304 returned to the emergency room the next day after demonstrating some type of seizure-like activity. Patient #304 stated that he had taken more pills. Hospital staff again searched the patient's rooms, but did not find any additional contraband or medications. Staff also changed some patient roommate assignments to different rooms. 3. On 06/05/18 at 9:55 AM, Surveyor #3 reviewed	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 144}	Continued From page 11 the medical record of Patient #304. The medical record showed: Patient #304 was admitted to the hospital on 05/14/18 with major depressive disorder after ingesting six bottles of "Nyquil" in an apparent suicide attempt. The hospital placed the patient on suicide observational checks every 5 minutes and self-harm precautions. By 05/30/18, the patient had progressed sufficiently to be on routine unit 15-minute checks and self-harm precautions. The night shift nursing progress dated 05/31/18 at 5:45 AM showed that around 7:30 to 8:30 PM, the patient took 4 "Xanax" bars and began to have an unsteady gait with slurring of words. The patient became combative when staff informed him that they needed to do a skin check for contraband and staff placed the patient in seclusion. While in seclusion, the patient became unarousable until a staff member applied a sternal rub to the patient's chest. The hospital then transferred the patient to a local hospital emergency room. The patient returned to the psychiatric hospital at 4:00 am on 05/31/18. The local hospital emergency department record dated 05/31/18 at 04:16 AM, showed that Patient #304 reported that he ingested approximately 8 mg of Xanax and was using it in a recreational manner at the psychiatric hospital. The patient denied any suicidal ideation or any other co-ingestions with alcohol or illicit drugs. The emergency room staff monitored the patient for several hours. The patient did not require any other interventions while in the emergency department.	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 144}	Continued From page 12 A seclusion/restraint form dated 05/31/18 at 12:50 PM, showed that Patient #304 was harming himself with a plastic utensil and did not respond to verbal de-escalation. Staff performed a physical hold to remove the utensil from the patient. The form also indicated that the patient "seemed to have suffered from seizure." Staff called '911' and emergency medical personnel transported the patient to the emergency room. A local hospital emergency department record dated 05/31/18 at 4:52 PM showed that emergency room staff evaluated Patient #304 for seizures. The record also showed "sometime between breakfast and lunch the patient stated that he took an additional 4 bars of Xanax". According to staff, the patient exhibited abnormal behavior. However, staff was not present and cannot provide any details. There was concern for seizure." The patient reported similar episodes in the past. Emergency room staff cleared the patient for release back to the facility. The patient's laboratory tests were determined to be benign. The patient was discharged with normal vital signs. The emergency room discharged the back to the facility with a final physician impression of benzodiazepine abuse. 4. On 06/05/18 at 1:30 PM, Surveyor #3 and Staff #302 interviewed Patient #303 about the "recreational drugs" brought into the hospital. Patient #303 stated that she brought 20 pills to the hospital that were located in a grocery bag among her belongings. She did not recall if the hospital staff searched her bag at the time of admission but did remember the staff removing a string out of her "hoody" sweat coat. Patient #303 stated that it is easy to hide things here because she is 'sneaky'.	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 144}	Continued From page 13 The surveyor asked Patient #303 if she gave drugs to any other patients. Patient #303 stated she was using pills when others asked if they could have some. She acknowledged sharing some with Patients #304 and #305. The surveyor asked Patient #303 what actions the hospital took after Patient #304 went to the emergency room. Patient #303 stated the staff searched the patient's rooms, did skin checks, and found four pills in her room. When asked by the surveyor if the hospital routinely checked patient rooms for contraband, Patient #303 replied she did not know if they did checks or not. She added, if they do checks routinely, the staff do not do a good job. As an example, she stated she had left a rice krispy treat in her room on the shelf for 3 days and staff failed to remove it. 5. On 06/05/18 at 1:40 PM, Surveyor #3 and Staff #303 interviewed Patient #305 about the drugs she brought into the hospital. Patient #305 stated she traded with Patient #303. Patient #305 stated that she exchanged "Xanax" for a sharp, which was a plastic piece of a spoon used for cutting or scratching oneself. Patient #305 also stated that Patient #303 later let her have more pills that she hid in her room. When the surveyor asked her what actions the hospital took after Patient #304 went to the emergency room, she stated, she does not remember because she was sleepy. Surveyor #3 asked her if the hospital routinely checked patient rooms for contraband. Patient #305 stated, " I think they do checks two times a day. They look everywhere and are trained where to look."	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 286}	Continued From page 14 PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on interview and review of quality documents, the hospital failed to ensure the system implemented to monitor corrective actions for previously identified deficiencies was robust enough to maintain patient safety. Failure to implement and monitor activities related to correction of previously identified safety concerns puts patients at risk of injury or death from substandard care.	{A 286}	**Plan of Correction for Each specific deficiency Cited (A286)** • The hospital failed to ensure that two forms of patient identification were used prior to medication administration. • The hospital failed to ensure that outside consultations were obtained in a timely fashion. **Procedure/process for implementing the plan of correction:** • An incident report was filed for the administration error immediately by the nurse. The CNO was made aware of the error and re-education and counseling were conducted by the nursing administration by an in-service on 6/5/2018 and 6/6/2018 with staff about two patient identifiers. • The patient identification policy was reviewed with all nurses along with the expectation for its use. • A policy was developed on obtaining consultations with outside providers on 6/22/2018 • Staff were educated on the new policy and process on 6/26/2018. Staff will not work a shift until educated on the new policy. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The Chief Nursing Officer (or designee) will randomly audit medication pass for a minimum of 15 patients a week, to ensure that proper patient identification is used prior to medication administration and will continue to do so until all medication	6/26/2018

passes inspected are carried out accurately 100% of the time for at least 90 consecutive days.

- The Chief Nursing Officer (CNO) will monitor 100% of all consult orders, daily/five days a week, to verify they were obtained in a timely fashion and will continue this monitoring until all consultation orders are carried out accurately 100% of the time for at least 90 consecutive days.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice

- The CNO will issue periodic reports to the PI Committee (at least monthly) on the status of obtaining outside consults and patient identification compliance.
- If the compliance falls below 90% the PI committee will require a new corrective action plan.

Individual Responsible:

- Chief Nursing Officer

Date Completed:
6/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 286}	Continued From page 15 Findings included: 1. During the previous federal complaint survey completed on 03/15/18, the hospital received a deficiency citation related to staff failure to use two patient identifiers prior to administration of patient medications. The hospital received a second deficiency citation for staff failure to use two patient identifiers during the current survey. On 06/04/18, during the current survey, staff failure to use two patient identifiers resulted in a medication error with need for medical follow-up for a patient who received another patient's medications. Cross Reference: A0405 2. During the previous federal complaint survey completed on 03/15/18, the hospital received a deficiency citation related to staff failure to provide timely medical consultation and outside referrals for patients who have medical needs. The hospital received a second deficiency citation for staff failure to provide an ophthalmology consult for a patient with an corneal abrasion and failure to provide timely access to a computerized tomography (CT) scan for a patient who had persistent headaches, nausea and blurred vision during the current survey. Cross Reference: A0068 3. During the previous federal complaint survey completed on 03/15/18, the hospital received a deficiency citation for failure to ensure the facility had sufficient nursing personnel to provide safe and effective care to patients. The hospital	{A 286}		

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{A 286}	Continued From page 16 received a second deficiency citation for the same issue during the current survey. Cross Reference: A0392 4. During the previous federal complaint survey completed on 3/15/18, the hospital received a deficiency citation for failure to ensure that staff referred a patient for a nutritional consult with a dietician for evaluation of nutritional deficiencies. The hospital received a second deficiency citation for the same issue during the current survey. Cross Reference: A0396 - Item #2	{A 286}		
{A 385}	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to ensure nursing staff were trained and available to provide safe and effective care for patient's health care needs. Failure to provide trained staff to meet patient needs risks deterioration of the patient's health status and delays in treatment. Findings included: The hospital failed to ensure that the number of	{A 385}		

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	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 385}	Continued From page 17 assigned and trained personnel were sufficient to allow for treatment planning and delivery of care as ordered by physician and/or the treatment team. The hospital failed to ensure that staff members followed standards of practice and hospital policy and procedure for patient identification prior to administration of medications. Due to the scope and severity of deficiencies cited under 42 CFR 482.23, the Condition of Participation for Nursing Services was NOT MET. Cross Reference: Tags A0392, A0396, A0405	{A 385}	**Plan of Correction for Each specific deficiency Cited (A385)** • While the staffing grid already delineated that all units must have at least one RN, it did not indicate whether the 2nd nurse should be an RN or LPN. **Procedure/process for implementing the plan of correction:** • The staffing grid was revised to delineate that the 2nd nurse (if any) may be an RN or an LPN. • An RN is always assigned to every unit every shift. • The staffing grid will clearly specify the required number of licensed nursing staff as RN (first line) an RN or LPN (second line) when a second nurse is required. • The nursing leadership team were educated on the new staffing grid on 6/26/2018 nursing will not work an additional shift until educated on the grid. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The Chief Nursing Officer (or designee) will audit all staffing sheets proactively to verify that an RN is scheduled to work every unit every shift and will continue to monitor those indefinitely. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice**	6/26/2018
{A 392}	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on document review and interview, the hospital failed to ensure the facility had sufficient nursing personnel to provide safe and effective care to patients. Failure to provide an adequate number of trained	{A 392}		

			• The CNO will issue daily reports to the CEO & CFO and periodic reports to the PI Committee (at least monthly) on the status of nurse staffing. **Individual Responsible:** • Chief Nursing Officer **Date Completed:** **6/26/2018**	

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	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 392}	Continued From page 18 registered nurses (RN), licensed practical nurses (LPN), and mental health technicians (MHT) risks patient safety and delays in care and treatment. Findings included: 1. Document review of the hospital document titled, "Nurse Staffing Plan," dated 05/17, showed that nursing care is to be provided by sufficient numbers of nursing staff members including registered nurses and licensed practical nurses to meet the identified nursing care needs of patient and family members twenty-four hours a day. Core staffing is based on the following critical factors: - Patient characteristics - The number of patients receiving care, including admissions, discharges and transfers - Intensity of patient care being provided - The variability of patient care across the unit -The scope of services provided, accounting for architecture and geography of the unit -The staff characteristics, including staff consistency, tenure, experience - The number and competencies of both clinical and non-clinical support staff the nurse must collaborate or supervise. 2. On 06/04/18 at 4:30 PM, Surveyor #3 reviewed the hospital nurse-staffing grid that was approved by the chief nursing officer on 03/09/18. The nurse-staffing grid was organized by clinical unit and patient census. Unit staffing was divided into two types of personnel: "nurses" and mental health technicians. The surveyor could not find any differentiation made on the staffing grid regarding the type of	{A 392}	**Plan of Correction for Each specific deficiency Cited (A392)** • The hospital documented that a registered nurse in orientation was the sole registered nurse assigned. **Procedure/process for implementing the plan of correction:** • The Chief Nursing Officer (or designee) provided training to the nursing leadership team that the RN of record for any unit must not be an RN in orientation. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The Chief Nursing Officer (or designee) will audit all staffing sheets proactively to verify that an RN who is not in orientation is scheduled to work every unit every shift and will continue to monitor those indefinitely. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice** • The CNO will issue daily reports to the CEO & CFO and periodic reports to the PI Committee (at least monthly) on the status of nurse staffing. **Individual Responsible:** • Chief Nursing Officer **Date Completed:** **6/26/2018**	6/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 392}	Continued From page 19 nurse required to staff the unit. The grid did not specify use of either a registered nurse or a licensed practical nurse as approved in the approved plan of correction. 3. A review of the daily staffing sheet utilized by the nursing supervisor for a fourteen-day period (05/21/18 - 06/03/18) revealed the following: a. The adult geriatric unit 1-West, which cares for adults 55 and older did not have a registered nurse assigned to the night shift for 1 of 14 nights. b. The adult unit 2-North, which cares for adults 18 years and older with acute mental illnesses to include psychosis had a registered nurse on orientation as the sole registered nurse assigned for 1 of 14 day shifts. 4. On 06/07/18 at 2:00 PM, Surveyor #3 interviewed the Chief Nursing Officer (CNO) (Staff #304) about nurse staffing for the hospital. The CNO stated that the grid does not differentiate between registered nurses and licensed practical nurses. The practice is that there is at least one registered nurse on each unit at all times. If the staffing grid calls for two nurses then the second nurse can be either a registered nurse or a licensed practical nurse. Additional staffing is added to the nursing unit when there is six patients on every 5-minute monitoring. Surveyor #3 reviewed the most recent two weeks of the daily staffing sheet utilized by the nursing supervisor with the CNO. He verified and confirmed the findings described above. Cross Reference: Tags A0396, A0405	{A 392}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 392}	Continued From page 20 THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 3/15/2018	{A 392}	**Plan of Correction for Each specific deficiency Cited (A396)** • The hospital failed to ensure that COWs & CIWA protocols were carried out and documented as order by the provider. • The hospital failed to ensure that nutritional screenings were carried out after identification from intake. **Procedure/process for implementing the plan of correction:** • A new COWs/CIWA policy was developed. • Nurses were re-educated on fully reviewing admitting documents for appropriate determination of a nutritional screening and alcohol-detox protocols per policy on 6/26/2018 any nurse not educated by the date will be required to be educated prior to working any additional shifts.. • Staff were educated on the new policy and process on6/26/2018 any nurse not educated by the date will be required to be educated prior to working any additional shifts... • A fulltime dietician has been hired and began work on 6/25/2018. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Under the direction of the Chief Nursing Officer, a member of the nursing leadership team will monitor 100% of the COWS & CIWA protocol and nutritional screening ,daily/five days a week, documentations until 100% compliance is met and sustained for at least 90 days.	6/26/2018
{A 396}	NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Item #1-CIWA Assessment Based on observation, interview, and review of hospital policies and procedures, the hospital failed to ensure staff members completed and documented care and treatment ordered by the physician for 4 of 6 patients (Patient #505, #507, #508 and #509). Failure to assess, treat, reassess, and document care in the medical record puts patients at risk for delayed or inadequate treatment and may result in patient harm. Findings included: 1. Document review of the hospital's protocol titled, "Alcohol Detox Protocol," revised 07/21/17, showed that staff should take a CIWA-AR (Clinical Institute Withdrawal Assessment for Alcohol -revised version) (a ten-item scale used in the assessment and management of alcohol withdrawal) score at the initiation of the protocol and then as ordered by the physician. The	{A 396}		

			• Nurses who do not properly carry out these protocols will be counseled as appropriate.. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice** • The CNO will issue periodic reports to the PI Committee (at least monthly) on the status of COWS & CIWA protocols. **Individual Responsible:** • Chief Nursing Officer **Date Completed:** **6/26/2018**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{A 396}	Continued From page 21 protocol has check boxes for the provider to order the CIWA-AR every two hours or every four hours. 2. On 06/05/18 at 2:30 PM, Surveyor #5 requested a policy or procedure related to alcohol detoxification or withdrawal. The Chief Nursing Officer (Staff #502) stated that the hospital utilized a CIWA protocol based on the provider order and there was no policy currently written. 3. On 06/05/18 at 2:00 PM, Surveyor #5 and a registered nurse (Staff #510) reviewed the medical record for Patient #507 who was admitted on 05/31/18 for alcohol use disorder, and post-traumatic stress disorder. The medical record review showed: a. On 05/31/18 at 4:00 PM, a Psychiatric Advanced Practice Nurse Practitioner (ARNP) (Staff #508) wrote an order for staff to complete a CIWA-AR assessment every two hours. The CIWA-AR flowsheet showed that staff completed the assessment: -On 06/01/18 at 12:40 AM and at then at 4:00 AM (a period of 3 hours and 20 minutes) -at 7:30 AM (a period of 3 hours and 30 minutes) -at 12:00 PM (a period of 4 hours and 30 minutes) -at 4:00 PM (a period of 4 hours) -at 8:00 PM (a period of 4 hours) -On 06/02/18 at 12:30 AM (a period of 4 hours and 30 minutes) -at 5:00 AM (a period of 4 hours and 30 minutes) -at 9:00 AM (a period of 4 hours) -at 2:00 PM (a period of 5 hours) -at 4:00 PM (a period of 2 hours) -at 8:00 PM (a period of 4 hours)	{A 396}		

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	504012	A. BUILDING _____ B. WING _____	R-C 06/07/2018

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{A 396}	Continued From page 22 -On 06/03/18 at 9:00 AM (a period of 13 hours) -at 1:00 PM (a period of 4 hours) b. On 06/03/18 at 2:50 PM, a Psychiatric ARNP (Staff #508) wrote an order to discontinue the CIWA-AR when the next three consecutive CIWA-AR readings were less than two. The last CIWA-AR assessment documented on the flow sheet was 06/03/18 at 1:00 PM prior to the new provider order. Surveyor #5 found no evidence that staff completed the CIWA-AR assessments as directed by the provider order. 4. At the time of the finding, Staff #510 stated that she thought the provider had changed the order for CIWA assessments to every 4 hours but verified there was no order reflecting the change in the medical record. At this same time, the psychiatric ARNP (Staff #508) stated she believed the staff had called her in the night but forgot to write an order. 5. On 06/05/18 at 2:30 PM, Surveyor #5, Staff #504, and Staff #505 reviewed the medical record of Patient #505 who was admitted on 05/18/18 for the treatment of alcohol addiction, suicidal ideation, and depression. The medical record review showed: a. On 05/19/18 at 12:45 AM, a provider wrote an order for staff to complete CIWA-AR assessments every two hours and every four hours. On 05/22/18 at 4:00 PM, a provider wrote an order to discontinue the CIWA-AR assessments. The CIWA-AR flowsheet showed that staff completed the assessments at varying times from every 2 hours to every 6 hours. 6. At this time, Staff #505 confirmed the finding	{A 396}		

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{A 396}	Continued From page 23 and stated that staff should have called the physician to clarify the order. 7. On 06/06/18 at 10:23 AM, Surveyor #5 and the Chief Nursing Officer (Staff #502) reviewed the medical record of Patient #508, who was admitted on 05/11/18 for treatment of schizophrenia and alcohol and opioid withdrawal. The medical record review showed: a. On 05/11/18 at 12:30 PM, a provider wrote an order for the CIWA-AR protocol. The provider failed to order the time frames for the CIWA-AR assessments leaving both options (every 4 hours or every 2 hours) blank. Review of the medical record showed that staff completed CIWA-AR assessments every 2 to 5 hours. 8. At the time of the review, Staff #502 confirmed the finding. 9. Review of the medical record for Patient #509 showed similar findings. Item #2-Nutritional Screen Based on interview, document review and medical record review, the hospital staff failed refer a patient for a nutritional consult with a dietician for evaluation of nutritional deficiencies for 1 of 4 patients (Patient #504). Failure to refer a patient for a nutritional consult may lead to poor nutrition and poor health outcomes. Findings included:	{A 396}		

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{A 396}	Continued From page 24 1. Document review of the hospital's form titled, "Nutritional Screen," showed that patients were to receive a referral for a nutritional consult when any of the referenced conditions were identified in a patient's screening including unplanned weight gain or loss. 2. On 06/04/18 at 3:30 PM, Surveyor #5 and a registered nurse (Staff #503) reviewed the medical record of Patient #504, who was admitted on 05/26/18 for the treatment of psychosis, depression and suicidal ideation. The medical record review showed: a. The intake call sheet dated 05/25/18 at 12:31 PM, showed that the patient had eating problems and a thirty-pound weight loss over the past five months. The admission medical history and physical examination did not address the patient weight loss. The initial nursing assessment completed on 05/25/18 at 5:30 PM, and the physician admitting orders completed on 05/26/18 at 5:30 AM showed that staff did not refer the patient for a nutritional consult. 3. At the time of the review, Staff #503 confirmed the finding and stated that she did not know why staff failed to order a consult. THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 3/15/2018	{A 396}		
{A 405}	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and	{A 405}		

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{A 405}	Continued From page 25 State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to ensure all hospital staff members followed its procedure for identification of patients prior to medication administration, as demonstrated by 5 of 11 patients observed (Patients #301, #302, #501, #502, #503). Failure to follow the hospital's patient identification process places patients at risk for medication errors and patient harm. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient Identifiers," no policy number, effective 05/17, showed that when	{A 405}	**Plan of Correction for Each specific deficiency Cited (A405)** • The hospital failed to ensure that two forms of patient identification were used prior to medication administration. **Procedure/process for implementing the plan of correction:** • The patient identification policy was reviewed with all nurses along with the expectation for its use by 6/26/2018 any nurse not educated by the date will be required to be educated prior to working any additional shifts. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The Chief Nursing Officer (or designee) will randomly audit medication pass for a minimum of 15 patients a week, to ensure that proper patient identification is used prior to medication administration and will continue to do so until all medication passes inspected are carried out accurately 100% of the time for at least 90 consecutive days. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice** • The CNO will issue periodic reports to the PI Committee (at least monthly) on the status of obtaining outside consults and patient identification compliance. **Individual Responsible:**	6/26/2018

			• Chief Nursing Officer **Date Completed:** **6/26/2018**	

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{A 405}	Continued From page 26 administering medications, the staff would use two patient identifiers. The hospital's approved patient identifiers include the patient's picture, the patient's name as given by the patient, with the patient's birth date as an alternate identifier. 2. On 06/05/18 at 8:25 AM, Surveyor #3 observed a medication administration for five patients on the Gero-Psychiatric Unit. The observations showed: a. The licensed practical nurse (Staff #301) failed to use two patient identifiers prior to administering Patient #301's medication. Staff #301 called Patient #301 by their first name, rather than asking them to state their full name or use another identifier. b. The licensed practical nurse (Staff #301) failed to use two patient identifiers prior to administering Patient #302's medication. Staff #301 called Patient #302 by their first name until prompted by the Nurse Educator (Staff #302) to ask the patient to state their name and date of birth. 3. On 06/05/18 at 9:45 AM, Surveyor #3 interviewed the licensed practical nurse (Staff #301) about patient identification procedures when administering medications. She stated that she asks patients their first name and their last name. If she has any concerns about who they are, then she asks them to state their birth date. 4. On 06/05/18 at 8:40 AM, Surveyor #5 observed a licensed practical nurse (Staff #501) as she administered medications to three patients (Patient #501, #502, and #503). Staff #501 failed to perform patient identification prior to medication administration as directed by hospital	{A 405}		

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{A 405}	Continued From page 27 policy and procedure. 5. At the time of the observation, the Chief Nursing Officer (Staff #502) confirmed thefinding and provided education to the licensed practical nurse on the hospital's policy and procedure for patient identification. 6. On 06/05/18 at 3:05 PM, Surveyor #3 reviewed the medical record of Patient #306 who was admitted on 04/07/18 for involuntary treatment. The review showed the following: On 06/04/18 at 5:00 PM, a progress note showed that at 10:30 AM, staff notified the attending physician that Patient #306 received another patient's medications by mistake. Patient #306 received a total of ten medications which included some over the counter medications, an eye medication for dry eyes, two oral hypoglycemic medications, Klonopin (medication used for anxiety), Gabapentin (medication used for seizures or nerve pain), and Effexor XR (a medication used for depression). The progress note revealed the nurse asked Patient #306 her name and the patient gave her another patient's name (Patient #307). The nurse then administered Patient #307's medications to Patient #306. THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 3/15/2018	{A 405}		